

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155799	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2013
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NAME OF PROVIDER OR SUPPLIER MARION REHABILITATION AND ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 WEST 14TH STREET MARION, IN 46953
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/09/13</p> <p>Facility Number: 012809 Provider Number: 155799 AIM Number: 200136580</p> <p>At this Life Safety Code survey, Marion Rehabilitation and Assisted Living Center was found not in compliance with with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, in areas open to the corridors and in resident rooms. The facility has a capacity of 70 and had a census of 34 at the time of this survey.</p>	K010000	<p>This Plan of Correction is prepared and executed because the provision of State and Federal law require it and not because Marion Rehabilitation & Assisted Living Center agrees with the allegations made in the cited deficiencies. The facility maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor are they of such character so as to limit our capability to render adequate care.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/16/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010021 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 18.2.2.2.6 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure once the fire alarm system is activated 4 of 4 sets of smoke barrier doors would remain self closing until the fire alarm system is returned to normal operations. This deficient practice could affect all occupants.</p> <p>Finding include:</p> <p>Based on observations with the plant operations director on 12/09/13 from 3:25 p.m. to 3:36 p.m., all four sets of smoke barrier doors released upon activation of the fire alarm system but when the system was placed in silence mode and the doors were opened, the magnetic hold open devices engaged causing all four sets of smoke barrier doors to remain open</p>	K010021	K021 Facility to correct the fire alarm system to ensure all smoke barrier doors remain self closing. The alleged deficiency had the potential to affect all residents. Facility to correct the fire alarm system to ensure all smoke barrier doors remain self closing. Maintenance Supervisor or designee to audit smoke barrier doors 2x/month for three months, 1x/month for three months then monthly thereafter. All results will be forwarded to the QA committee monthly. To be completed by January 8, 2014.	01/08/2014			

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	<p>instead of self closing. This was acknowledged by the plant operations director at the time of observations.</p> <p>3.1-19(b)</p>				

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K010038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 9 of 10 exit doors in the path of egress equipped with a magnetic locking system, remained unlocked with activation of the building fire protective signaling system. LSC 18.2.1 requires every corridor and exit be in compliance with Chapter 7. LSC 7.2.1.6.2.(d) requires actuation of the fire alarm system shall unlock the doors in the direction of egress and the doors shall remain unlocked until the fire alarm system has been manually reset. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the plant operations director on 12/09/13 between at 3:20 p.m. to 3:36 p.m., the exit doors equipped with a magnetic locking system, failed to remain unlocked when the fire alarm system was placed in silence mode. The magnetic locking system was disengaged at the main entrance. This was acknowledged by the plant operations director at the time of observations.</p> <p>3.1-19(b)</p>	K010038	K038 Facility to correct the fire alarm system to ensure all exit doors remaining unlocked until the fire alarm system has been manually reset. The alleged deficiency had the potential to affect all residents. Facility to correct the fire alarm system to ensure all exit doors remaining unlocked until the fire alarm system has been manually reset. Maintenance Supervisor or designee to audit all exit doors 2x/month for three months, 1x/month for three months then monthly thereafter. All results will be forwarded to the QA committee monthly. To be completed by January 8, 2014.	01/08/2014			

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K010044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets was arranged to automatically close and latch. LSC 18.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects 2 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the plant operations director on 12/09/13 at 1:13 p.m., the right side door of the fire door set entering the D wing failed to latch into the frame when tested. The plant operations director acknowledged these doors were fire doors and the right side door failed to latch into the frame.</p> <p>3.1-19(b)</p>	K010044	<p>K044Facility to fix the D-Wing Fire Door. Facility to audit all other fire doors to ensure closing and latching properly.The alleged deficiency had the potential to affect all D-Wing residents. Facility to fix the D-Wing Fire Door as well as any other Fire Door not latching properly.Maintenance Supervisor or designee to audit all fire doors 2x/month for three months, 1x/month for three months then monthly thereafter. All results will be forwarded to the QA Committee monthly. To be completed by January 8, 2014.</p>	01/08/2014			

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K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to document and conduct weekly tests of 1 of 1 fire pumps in accordance with LSC Section 9.7.5 and 18.3.5.1 and NFPA 25. NFPA 25, Table 5-1.1 and then 5-2 through 5-3.2.4.4 requires the following weekly inspections: the pump house conditions-heat is at least 40 degrees F, heating ventilating louvers are free to operate, fire pump system conditions with valves fully open, piping free of leaks, suction line pressure gauge reading is normal, suction reservoir is full. Additionally, NFPA 25. 5-3.2.1 requires a no flow, ten minute pump test shall be performed weekly. This deficient practice affects all occupants.</p> <p>Finding include:</p> <p>Based on record review with the plant operations director on 12/09/13 at 12:00 p.m., the facility was unable to provide documentation of a weekly inspection of the fire pump. Based on interview with the plant operations director at the time of record review, he was unaware of this requirement.</p>	K010062	K062Facility cannot correct the alleged deficiency due to occurring in the past.The alleged deficiency had the potential to affect all residents.Maintenance Supervisor to be in-serviced regarding completing weekly fire pump tests. Audit to be added to the facility electronic auditing tool (TELS).Maintenance Supervisor or designee to audit the fire pump tests weekly for four weeks, 2x/ month for two months then monthly thereafter. All results will be forwarded to the QA committee monthly.To be completed by January 8, 2014.	01/08/2014			

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K010130 SS=D	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the plant operations director on 12/09/13 at 3:00 p.m., there was a rolling fire door protecting the basement service areas from the receiving area. Based on interview with the plant operations director at the time of observation, the rolling fire door did not receive an annual inspection.</p>	K010130	<p>K130Facility cannot correct the alleged deficiency due to occurring in the past. The alleged deficiency had the potential to affect facility staff only as it was not in a resident care area. Maintenance Supervisor to be in-serviced regarding completing an annual rolling fire door test. Audit to be added to the facility electronic auditing tool (TELS). Maintenance Supervisor or designee to audit for annual fire door tests monthly for 6 months. All results will be forwarded to the QA committee monthly. To be completed by January 8, 2014.</p>	01/08/2014			

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintaining the minimum exhaust gas temperatures, or at not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident in the facility.</p>	K010144	K144Facility cannot correct the alleged deficiency due to occurring in the past.The alleged deficiency had the potential to affect all residents. Maintenance Supervisor to be in-serviced regarding completing an annual generator load test. Facility to obtain and complete the annual generator load test. Maintenance Supervisor or designee to audit for annual generator load test monthly for 6 months. All results will be forwarded to the QA committee monthly.To be completed by January 8, 2014.	01/08/2014			

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	<p>Findings include:</p> <p>Based on record review of the "Emergency Generator Documentation Checklist" with the plant operations director on 12/09/13 at 11:40 a.m., the generator test log showed a monthly load test for the past twelve months but the log did not indicate if the diesel generator was exercised under operating conditions, maintaining the minimum exhaust gas temperatures, or not less than thirty percent of the EPS nameplate rating monthly, for a minimum of thirty minutes. Based on an interview with the plant operations director at the time of record review, he stated the previous load bank test on the emergency generator was March 12, 2012. He was unable to provide documentation confirming the generator was exercised under operating temperature conditions, maintaining a minimum exhaust gas temperatures, or operated at not less than 30 percent of the EPS nameplate rating.</p> <p>3.1-19(b)</p>				

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K010161 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD All elevators, escalators, and conveyors comply with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. 9.4, 18.5.3 Based on observation and interview; the facility failed to ensure 1 of 1 elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect any residents, as well as visitors and staff in the elevator if the sprinkler system was activated in the elevator equipment room.</p> <p>Findings include:</p> <p>Based on observation with the plant operations director on 12/09/13 at 2:30 p.m., the elevator equipment room was provided with a sprinkler and a smoke detector. Based on interview at the time of observation, the plant operations director was unable to confirm a shunt trip for the elevator machine equipment</p>	K010161	K161Facility to locate or add Shunt Trip for elevator.The alleged deficiency had the potential to affect all residents and staff.Facility to locate or add Shunt Trip for elevator. Maintenance Supervisor or designee to audit elevator for shunt trip and functioning properly monthly for 6 months. All results will be forwarded to the QA committee monthly.To be completed by January 8, 2014.	01/08/2014			

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